

King County Health Reform Initiative Check-Up: Peer Review Panel Findings

Prepared by:

Clegg & Associates, Inc.

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Prepared by:
Clegg & Associates, Inc.
1904 Third Avenue, Suite 925
Seattle, WA 98101
(206) 448-0878
www.cleggassociates.com

- **❖ Judith Clegg, Project Lead**
- **Beka Smith, Research Associate**
- **❖** Natalie Moe, Administrative Assistant

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Executive Summary

In 2003, King County Executive Ron Sims launched an ambitious initiative to dramatically change the local health care landscape. The County Executive's goals were to improve the quality of the local health care system, to elevate the health status of County employees and their dependents, to transform the County into a work environment that supports employee and dependent health, and to slow down the major increases in health care costs facing the County.

Working collaboratively with the County's Joint Labor Management Insurance Committee (JLMIC) and local health care experts, the County developed the Health Reform Initiative (HRI), a comprehensive approach to achieving its goals. Figure 1 below depicts the interlocking nature of the HRI's major components.

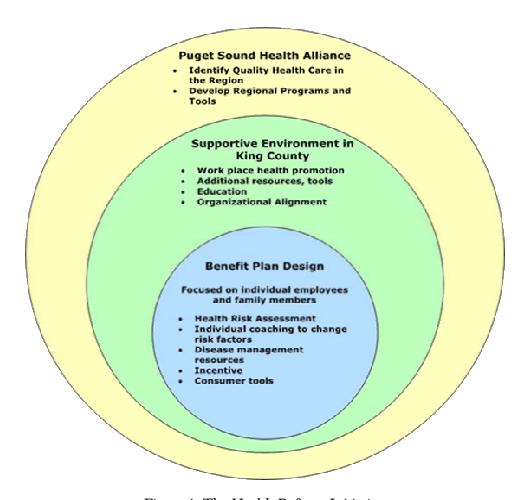


Figure 1: The Health Reform Initiative

Implementation of the components has proceeded quickly: benefit plan design innovations were underway by early 2005; work to create a more supportive environment for health in the County began in the spring of 2005; and the Puget Sound Health Alliance formed at the end of 2005. Timing is important, as the County is committed to achieving a slow-down in the rapidly increasing cost of health care for employees and dependents during the 2007 to 2009 time period.

As part of the design-implement-evaluate-revise quality improvement cycle built into the HRI, the County took advantage of preliminary results from the initiative's first year to ensure that the program design and implementation were on track. The County also hoped to identify program adjustments or new developments in the field that could help maximize progress toward the HRI's key goals of slowing the rate of rising employee health care costs and improving employees' health. To this end, the County selected five experts to take a rigorous and objective look at the HRI's performance to date and identify opportunities for improvement. Panelists were chosen for their expertise in fields most relevant to the HRI: wellness outreach and education, prevention, benefit plan design, measurement and evaluation, and pharmacy plan design and strategy. The table below shows the panelists and their fields of expertise.

Panelist	Area of Expertise		
John Garner, CEBS, CLU, CFCI, CMC Garner Consulting	Benefit Plan and Design		
Jeffrey Harris, MD, MPH, MBA Associate Director Health Promotion Research Center	Prevention		
Pete Penna, PharmD President Formulary Resources, LLC	Pharmacy Plan Design and Strategy		
Neal Sofian, MSPH CEO The NewSof Group	Wellness Outreach and Education		
Cindy Watts, PhD Professor, Health Services University of Washington	Measurement and Evaluation		

The panel, convened by consultants Clegg & Associates, met in an all-day session at the University of Washington on Friday, September 15th. While it was too early in the implementation process to conduct a definitive evaluation of the HRI, the panel was able to look at the first year of program data and assess whether preliminary indications suggest that the program design and implementation will help the County achieve its employee health and health care cost goals. Panelists provided suggestions in a number of domains on how the HRI could maximize its outcomes and effectively track and measure results.

The panelists focused on the following questions:

- 1. What does the first year of implementation tell us about the soundness of the design and assumptions underlying the HRI?
- 2. To what extent do the results from 2005 suggest that the first year of implementation has put the county on track to realize its goals of improving employee health, bringing about organizational change, and slowing cost increases? Have communication strategies, e.g., messaging, supported implementation effectively?
- 3. Given the data available from the first year of implementation, what adjustments would you recommend?
- 4. Thinking about the future, what will be necessary to ensure that changes are sustainable? Are there any developing trends that could positively or negatively impact the HRI over the next three to five years?

The following sections summarize the panel's input on these questions.

1: Program Design

Early results support the soundness of the HRI's overall program design and underlying assumptions.

Cautioning that one year of results is insufficient to draw firm conclusions, panelists generally agreed that the program is well designed and that its combination of best-practice strategies is innovative. The first year of data, while inconclusive, did not cause doubt for panelists about the overall soundness of the program design or its underlying assumptions.

Multi-level approach: Efforts to promote healthy culture and practices within the county workforce, while at the same time generating an initiative to improve the health care system county-wide, reciprocally support success at both levels. While one panelist noted that greater publicity about the regional approach and increased employer buy-in will be needed in the long run, the panelists found the multi-level approach to be a promising and highly proactive strategy.

Health risk assessments: Extremely high rates of participation in health risk assessments (HRAs) suggest that program incentives were well-designed. The panelists encouraged the HRI to focus on moderate risk employees, preventing expensive serious conditions while avoiding a minimal return on investment from strategies targeted to young, low-risk employees.

Disease management: Panelists held varying professional views about the general effectiveness of disease management. Insufficient data have been gathered at this point to establish the effectiveness of disease management approaches, but the panelists encouraged the County to retain disease management as one of its strategies, particularly as program results are guaranteed in the contract with the vendor. Panelists also noted high rates of participation among county employees with congestive heart failure, coronary artery disease, and diabetes as a positive preliminary indicator.

Nurse advice line: Program data from the nurse advice line included both potentially positive and negative elements. High rates of employee participation indicate that the nurse advice line is useful, but the percentage of calls asking for assistance in deciding whether to go to the emergency room seemed low to some panelists. They suggested that the County may want to compare these figures with employers using similar programs and monitor types of inquiries. The panel warned that nurse lines, in general, also can struggle with liability issues limiting what nurses can advise and need to carefully document conversations in order to avoid giving inconsistent or contradictory information to callers.

Flu shots: Panelists approved of County initiatives to offer flu vaccinations at work sites, and encouraged the County to further increase participation by adding more worksites and including employees' dependents, as vaccinations can potentially save considerable short-term resources in both health costs and lost work time.

MedQuery: The MedQuery system identified thousands of variations from best practice protocol and more than a third of physicians responded by reviewing and making the recommended changes in treatment. This suggests that more employees are receiving best practice care. However, nearly two-thirds of identified variations resulted in no change in treatment. The program will need to be examined further in order to understand whether physicians' actions were appropriate and to avoid fatiguing physicians with too many, or improper, notifications.

Pharmaceutical costs: Pharmaceutical strategies were particularly difficult to assess based on preliminary data available to the panel. Although the panelists did not indicate early signs of concern, more time and data will be needed before findings can be interpreted in this area.

2: Implementation

Early indications suggest that the HRI has been well-implemented overall and that, at this point, the County is on track to see positive results in employee health, costs, and organizational culture. High rates of participation suggest that communication strategies have effectively reached many employees.

While cost and health outcomes will likely not be documented until HRI strategies have been underway for years, early signs are encouraging. At this early point in implementation, participation rates are appropriate to use as tentative indicators of success and County employees are participating in the HRI at high rates.

Participation: The extremely high level of participation in HRAs is a promising sign for long-term results. However, not all participants will make long-term changes. The HRI will need to focus on supporting adherence and long-term commitment to healthy practices.

High disease management participation rates are also promising, as these strategies can help employees and their dependents move from catastrophically ill to chronically ill risk categories, which will improve both health and cost results.

However, the panel also encouraged the HRI program to pay attention to which employees are not participating. With sensitivity to avoid employee concerns about profiling, the County should examine whether nonparticipation occurs at a higher rate among certain groups, such as divisions based on job type, ethnicity, age, reading level, or other categories. This type of analysis will help identify obstacles to participation and may help the County tailor messages to more effectively reach different groups.

Communication: Panelists agreed that current messages appear to be effective. Communication is an essential component of HRI strategies and therefore deserves careful tracking as implementation progresses. This will be particularly important as employees begin to pay higher out-of-pocket expenses for failing to participate actively in the program and may become resentful. It will also be important to communicate effectively with providers, particularly as they receive notifications from MedQuery about deviations from best practices and as consumers are encouraged to ask questions about their treatment programs.

Panelists highlighted HRI communication strategies targeting middle managers as particularly impressive in conveying both the importance and the nuts and bolts of the HRI. They also praised the multiple modes of communication employed, including face-to-face communication, leadership meetings, information sessions, and the internet. They encouraged the HRI to watch for further opportunities to be innovative, such as integrating phone and web coaching, for example, or, with employees' permission and with attention to frequency, using text messages to cell phones. Innovative communication strategies should also take into account the different ways that people learn and act. Unions, critical in supporting participation so far, can also continue to help the HRI communicate with employees.

Panelists felt that there was opportunity for more communication about pharmaceutical issues, flu shots, and tobacco cessation. Communication about flu shots should combat messages employees receive from other sources that flu supplies are needed for older and frailer people, which may discourage them from getting vaccinated. Panelists recommended that the County consider timing its communication so that a few weeks after older people receive the first round of vaccinations, employees can be encouraged to get the second round of shots before the peak of flu season.

Communication also needs to target dependents. They can be more difficult to reach than employees, but need to receive information about disease management strategies, both for themselves and to support their spouses and partners.

Workplace culture: Panelists noted early success in changing workplace norms to support healthy behaviors and to create a culture of questioning patients. However, long-term changes in organizational culture will take time to develop and require sustained efforts.

Indirect cost savings: Panelists cautioned the County against measuring success based only on claims reports, which do not address reductions in indirect costs, such as improvements in productivity, absenteeism, and turnover. Savings in these indirect costs have not yet been measured, but panelists anticipate that the results will be good. Panelists recommended proxy measures such as the Work Limitations Questionnaire (WLQ) and the Work Productivity and Activity Impairment Questionnaire (WPAI) and encouraged the County to establish baseline data on absenteeism, turnover, and productivity in order to measure improvements in the future.

Pharmacy: Data on pharmaceutical initiatives was insufficient, but did not appear to signal immediate areas of concern. Panelists encouraged the HRI to focus on the use of generic drugs, such as advance planning for when drugs become available in generic forms, analyzing among the County workforce which brand-name drugs are incurring the highest expense, and tracking which doctors are prescribing the most expensive drugs. Pharmaceutical strategies should be communicated clearly to patients, doctors, and pharmacies.

Logistical problems: While implementation appeared to be smooth overall, a few minor difficulties, such as rescheduling coaching sessions and inadvertent changes made to employee exercise logs, should be quickly corrected. Attention to these details will help demonstrate to employees that the County considers the initiative important.

3: Adjustments

While urging the County to "stay the course" and give HRI strategies time to succeed, panelists offered suggestions to maximize results in a number of areas. Many of these suggestions focused on measurement and evaluation.

As early indications suggested that the HRI strategies were well designed and implemented, panelists focused on additional steps the County could consider that would build on existing strategies.

On-site services: Panelists suggested that the County consider offering onsite medical care at some County facilities, which would both decrease absenteeism by reducing travel time to appointments and provide another avenue for communicating with employees about disease management. On-site pharmacies have been effectively used by other employers in large facilities to increase use of generic drugs and improve treatment compliance. On-site exercise facilities are also particularly effective in increasing women's physical activity and would positively demonstrate the County's commitment to health.

Disease screening: Panelists suggested adding disease screening to HRI strategies, particularly for diseases with high-impact and high-value interventions, such as alcohol use, blood pressure, cholesterol, and breast, cervical, and colon cancer.

Risk categories: Panelists praised the HRI's risk category approach to interventions and encouraged the County to continue to refine its categorization system and related health interventions. For example, the County may want to consider how combinations of different risk factors can negatively interact with each other to create potentially dangerous conditions for employee health that could be directly targeted with preventive strategies.

Pharmacy: Panelists encouraged the County to develop its ability to query pharmaceutical data, particularly with a system that would allow a connection between pharmaceutical utilization and medical data, which they warned may be a challenging endeavor. They also advocated measuring the rate of adherence to recommended treatment actions and the percentage of patients who reach their prescribed treatment goals. For those plan members who do not adhere to their treatment regimes, the panel recommended further investigation in order to identify trends and address obstacles.

Peer coaching: Panelists recommended that the County explore peer coaching, an inexpensive intervention that can build motivation by connecting employees with people to whom they can relate. Peer coaching could also target dependents.

Partnership opportunities: The panel suggested that the County might want to explore experimental co-development in its implementation of the HRI's innovative package of services. With a corporate co-sponsor, the County could document the HRI approach and results for other communities' and employers' use. The County would share in the vendors' profits and the additional funding could support HRI program components.

Self reporting: Currently the HRI depends on employees to report on their actions in order to qualify for incentives. This is appropriate for the current effort to maximize participation, emphasizing positive rather than punitive values, but in the future, the County may want to consider how to monitor truthfulness in self reporting. Adding biometric measures to the health risk assessment was suggested as one way to monitor self reporting. It is both difficult and dangerous to monitor truthful self report and may not be worthwhile, as employees will easily become resentful of efforts to check up on them, but this is an issue for the County to keep in mind.

Measurement and evaluation: In the long term, monitoring whether the HRI is on track will require more information. Currently outcomes are based on participation, which is appropriate during this early stage of implementation. However, in the future, health and cost results will need to be an outcome and measurement focus. Panelists recommended that the County move toward measuring intermediate outcomes, particularly employee health behaviors such as physical activity, tobacco cessation, and flu shots. Panelists also encouraged the County to consider evaluating HRI success based on changes in employees' risk levels.

The panel highlighted the importance of identifying peer groups that could be used for comparing rates of increasing costs. Ideally, a nearby county with a similar population that is not undertaking substantial health reform initiatives would be a good control group to put King County results and costs in context.

Panelists proposed a number of additional potential areas to measure, including stress, life satisfaction, and employee knowledge and attitudes. The panel encouraged the County to develop a better system for tracking time loss and measuring the expected gains in work time stemming from HRI strategies.

The HRI can access measurement data from multiple sources. In addition to program information and surveys, panelists encouraged the County to develop agreements with vendors to provide aggregated information on participation and health outcomes and needs.

The panel recommended that the County take a big-picture approach toward evaluation. It will be difficult to determine which strategies are causing changes within the multi-pronged HRI approach and therefore it may be best to assess the HRI as a whole. Due to the likely interplay among the initiative's different elements, results from a single program component can be misleading. For example, it is important to look at pharmacy and inpatient costs together, as higher pharmacy costs may be tied to lower inpatient costs. For this reason, the panel discouraged the County from reducing program success to a single cost-benefit figure. Similarly, the panelists also encouraged the County to consider investment and benefits in both quantitative and qualitative terms, including changes in behavior and work atmosphere.

4: Sustainability

Successfully sustaining the HRI will require long-term strategies, persistent and consistent communication with various groups, and monitoring. The County will also need flexibility to make changes as needed and patience to see significant outcomes in health and costs, which panelists believe may not be documented for five years.

The HRI focuses on changing employee, workplace, and community norms, which will require years of sustained effort. Strategies to promote long-term healthy behaviors and attitudes should increase awareness, motivate, and build social support to help employees improve their health. While programs and strategies may change, the basic messages should remain consistent.

Motivation: The County has done excellent work in motivating employees at the onset of the HRI. It will be important to maintain motivation and enthusiasm in the coming years. Motivation can be built through competitions, incentives, or peer groups. Keeping HRI programs easy to use will also help maintain motivation.

In the long term, panelists encouraged the County to consider how closely incentives are tied to behaviors. For example, the County might want to shorten time periods between qualifications for benefit levels.

Panelists encouraged the County to explore multiple strategies to motivate employees to choose generic drugs, including increasing the co-pay for brand-name drugs when a generic is available or rewarding long-term adherence to prescribed medication by refunding a portion of co-pays.

Motivation also depends on employees of all job types believing that the HRI will reach its goals in containing cost increases and improving employee health. Panelists urged the County to share data with employees showing their accomplishments. The panel also encouraged the HRI to publicize its positive results to other stakeholders and the general community in order to sustain interest and support for HRI programs. Rather than waiting to report on program successes once each calendar year, the panel encouraged the County to share information when it becomes available and interest is high.

Communication: HRI programs should consistently reinforce basic messages about healthy eating, physical activity, and prevention. However, panelists encouraged HRI staff to consider a cyclical approach to communication with alternating emphases, in order to maintain interest. For example, this might include tips for physical activity and healthy eating based on seasonal changes.

Efforts to build regional community support for healthy initiatives will benefit from tools to facilitate communication between employers and healthcare institutions. Panelists recommended using websites that would allow organizations to share their strategies and resources and build a repository of best practice information.

Measuring and reporting: Finding routine and informative ways to analyze data from HRI programs will be important in order to identify trends and make adjustments. For example, issuing a standard set of reports on pharmacy benefits will help the County identify potential cost savings and patients at risk.

Managing expectations: The HRI may be in place for five years before results are documented. During those years, political leadership and priorities may change. In order to sustain the HRI over the long term, the County will need to communicate effectively about the HRI and its mission, as well as convey reasonable expectations about outcomes.

External trends: Panelists cautioned that health care costs are likely to continue to increase at high rates. It will therefore be important for the County to measure the HRI's success by comparing changes in King County's health care costs to the increases experienced by similar employers, rather than relying solely on initial estimates.

The panel also encouraged the HRI to monitor health insurance trends among private sector employers. If the County finds that private employers are increasingly not providing any health insurance for their workforce, it will make the HRI's regional strategies to engage employers more difficult.

Given the HRI's long-term and multi-faceted approach, the panel encouraged the County to remain aware of and responsive to external trends that may help or hinder the initiative's progress in improving employee health and slowing cost increases. For example, the passage of Initiative 901 may impact the HRI's smoking cessation efforts. The HRI should watch for potential push-back from smokers, as well as potential positive reinforcement for cessation as people begin to expect smoke-free public places.

Overall, the panel found the HRI to be well-designed, appropriately implemented, and initially promising in its efforts to deliver results in employee health and slowed cost increases. Panelists encouraged the County to continue to track and build on successes, remain vigilant for internal and external changes, and hone strategies for maximum participation and effect.

Independent Peer Review Questionnaire Responses

John Garner, CEBS, CLU, CFCI, CMC

Garner Consulting

Area of Expertise: Benefit Plan and Design

1: Program Design

What does the first year of implementation tell us about the soundness of the design and assumptions underlying the HRI?

In general, it is too early to draw any conclusions about the soundness of the program design and assumptions underlying the Health Reform Initiative. Since 2005 was intended to be the year for establishing reference points for measuring changes, this is not surprising.

Nonetheless, the following facts seem to indicate that the program design is sound:

- King County employees and their families used the nurse advice line at twice the rate of
 other employers who subscribe to Aetna's Informed Health Line. This indicates that the
 nurse advice line is meeting a need.
- King County members identified with congestive heart failure, coronary artery disease or diabetes participated in the disease management programs at slightly higher rates than members in other plans in Aetna's book of business. This indicates that the disease management programs are meeting a need.
- The Enhanced Member Outreach nurses successfully contacted 799 members whose claim profiles indicated they qualified for the EMO services. While book-of-business comparisons are not available from Aetna, the potential return on investment of this program is so high that this number must represent significant savings, if not in the current year, then in the not-too-distant future.

• The MedQuery program identified 3,213 instances where the claim data indicated a variation from best practice protocols and the member's physician was notified. Early claim data indicate that 36.8% of physician contacts by MedQuery led physicians to review their treatment plans, determine there were no mitigating circumstances not shown in the claim data and make the changes recommended in the MedQuery best practice protocol. This means that almost 1,200 King County participants are now receiving best practice care, rather than some variation.

On the other hand, the following facts may indicate a need for adjustments in the program design:

- Only 5.7% of calls to the nurse advice line were for assistance in deciding if the member needed to go to the emergency room or could wait to make an appointment. This seems low, but it would be helpful to know Aetna's overall experience.
- Over 3,000 employees received flu shots at various work locations around the county at no charge to benefits-eligible employees. While this is a significant number, it leaves a great deal of room for improvement.

I suggest:

- Looking into expanding the number of conditions targeted for disease management, while assuring that participants with comorbidities are treated in a holistic manner.
- Getting data from Aetna regarding the percentage of calls for their book of business to
 the nurse advice line for assistance in deciding if the member needed to go to the
 emergency room or could wait to make an appointment.
- Expanding free flu shots to include dependents.

In general, the HRI appears to be well designed.

2: IMPLEMENTATION

To what extent do the results from 2005 suggest that the first year of implementation has put the county on track to realize its goals of improving employee health, bringing about organizational change and slowing cost increases?

The Health Reform Initiative is a complex program, with many components. Encountering problems in the implementation of such a program is not unusual.

The following facts seem to indicate that the first year of implementation has put King County on track to realize its goals:

- Almost 1,400 participants are now in the disease management programs. Many of these
 individuals are considered catastrophically ill, but with the assistance of the disease
 management programs, can move into the chronically ill part of the spectrum, improving
 their health and slowing cost increases.
- Almost 1,200 participants are now receiving best practice care as a result of the MedQuery program. Best practices should improve health and often decrease costs.

The following facts seem to indicate that there were issues during the first year of implementation that can be corrected or avoided in the future:

- Because of the large volume of last-minute enrollments, Harris HealthTrends had to reschedule some coaching calls.
- Harris HealthTrends made some modifications to the "Get Fit on Route 66" log that inadvertently changed the exercise times that participants had already entered.
- King County encountered conflicting data sources regarding the county organization and hierarchy that affected the registration forms for the Live Well Challenge.

I would like more information on the following subjects:

- The September 1, 2005 report on measurement & evaluation design describes the Quit
 Tobacco Campaign as part of the Live Well Component of the HRI; however the 2005
 Measurement and Evaluation Report issued in August 2006 does not list the Quit
 Tobacco Campaign. What happened to it?
- The September 1, 2005 report on measurement & evaluation design describes the Choose a Health Provider Campaign as part of the Choose Well Component of the HRI; however I did not see mention of this in the 2005 Measurement and Evaluation Report issued in August 2006. What happened to it?
- The September 1, 2005 report on measurement & evaluation design describes the Specialist Efficiency Service as part of the Provider Performance Component of the HRI. The 2005 Measurement and Evaluation Report issued in August 2006 mentions the Aexcel program, which appears to correspond to the Specialist Efficiency Service. The latest report indicates that there are no incentives in the plan to "push" members to use the Aexcel network providers, yet approximately 79% of KingCare members who visited specialists in 2005 did so. This suggests that either the threshold for specialists to be members of the Aexcel network is too low or that King County does not need this program. Why were no incentives built into the program? What is Aetna's criteria for designating a specialist to be part of this network?

In general, the first year of implementation of HRI appears to have gone reasonably well.

Have communication strategies, e.g., messaging, supported implementation effectively?

Based on my review of the materials provided and the web site, I say "yes" the message supported the implementation.

3: ADJUSTMENTS

Given the data available from the first year of implementation, what adjustments would you recommend?

Programs like MedQuery are quite promising, but still in their infancy. While the program identified almost 1,200 situations where people could and did have their treatment modified to conform to best practices, the flip side is that over 60% of the contacts did not result in a change to best practices. This probably is for a combination of reasons. In some instances, physicians may not have bothered to review their records. In other situations, the treatment provided may have been the best course of action given that particular patient's situation. These programs run the risk of alienating physicians if too many letters are sent out in situations where the care is already appropriate. King County should confirm that Aetna is actively managing this program to refine the protocols. This means that Aetna should identify situations in which MedQuery has flagged a patient as potentially having an opportunity for improvement in care that does not really exist. It should be possible to improve the program over time by identifying the reasons for "false positives" and changing the screening criteria to delete them.

4: SUSTAINABILITY

Thinking about the future, what will be necessary to ensure that changes are sustainable? Are there any developing trends that could positively or negatively impact the HRI over the next three to five years?

In order to be sustainable over the long term, all stakeholders will need to feel that the program is reasonably easy to use and believe that it will achieve its intended goals. The problems identified above (lags in scheduling coaching calls and data errors in online logs and related to registration for HRI programs) must be corrected. If King County cannot put the resources into correcting problems as they arise, the plan participants and other stakeholders, such as supervisors and managers, will not believe that upper management is serious about the HRI.

In order for all the stakeholders to believe that the HRI will achieve its intended goals, the data will need to show that employees are in better health and that cost increases are coming down. That remains to be seen, but the early results are promising.

A number of factors will continue to drive health care costs. In measuring the success of HRI, it will be important to measure against the experience of other plans, not current projections.

Jeffrey R. Harris, MD, MPH, MBA

Associate Director, University of Washington Health Promotion Research Center

Area of Expertise: Prevention

1: Program Design

What does the first year of implementation tell us about the soundness of the design and assumptions underlying the HRI?

In answering this and the other questions, I have generally divided my answers into three separate parts, for the two major program areas of the Health Reform Initiative (HRI), Employee Wellness and Utilization Management, as well as for the sought-after Cost Outcomes.

Employee Wellness

The best information from the first year relates to participation in the Health Risk Assessment (HRA) required for employees to be eligible for lower cost-sharing (via deductibles, co-pays, and co-insurance). Participation in the HRA was 90%, an exceptionally high level. This suggests that graduated cost-sharing was an effective incentive for HRA participation. A recent review by the Task Force on Community Preventive Services (www.thecommunityguide.org) of the Centers for Disease Control and Prevention (CDC), suggests that HRA participation is much more effective at inducing adoption of healthy behaviors if it is accompanied by individual-level coaching. King County's program includes such coaching, but, in the materials provided to me for review, I did not find information on levels of participation in coaching. I would also like to know whether HRA participation was as high among covered dependents as it was among employees.

More information on other Employee Wellness efforts is also needed, both for program management and for this review. For each of the major program components below, I have reviewed what we know and what we need to know. I will focus first on flu vaccination and

tobacco cessation because these are among an employer's best opportunities for fostering near-term decreases in employee health-care utilization and increases in productivity.

- Flu vaccination—3,000 employees (about one quarter of employees) received the vaccination in the workplace in 2005. What proportion of employees work in sites where vaccination was offered? What proportion of employees overall received flu vaccination in 2005?
- Tobacco cessation—Because tobacco cessation services are provided largely as a health insurance benefit via King County's health plans, there is little or no information on employee participation in the cessation program. What proportion of smokers participated in a tobacco cessation program in 2005? How many quit? What is the prevalence of smoking?
- Health & Benefits Fair—2,000 employees (about one sixth of employees) attended.
 What did they do? What did they learn? What disease screening did they receive?
- Eat Smart—How many worksites had healthier foods added to vending machines? What proportion of employees do these worksites employ? Do vendor records suggest that the healthier foods are selling? If not, has there been an attempt to determine which healthier foods might be more popular?
- Move More—What are the programs that were added in 2006? Do they follow the recommendations of the Task Force on Community Preventive Services and include individual activity choices and group support for activity? Are the programs set up to be continued for at least a year, if not several years? What are the employee participation levels? What proportion of employees is physically active at the CDC-recommended levels (30 minutes of moderate 5 days a week, or 20 minutes of vigorous 3 days a week)? What proportion of employees is overweight (BMI 25-29.9) or obese (BMI ≥30)?

Utilization Management

The review materials focused heavily on this topic. The five programs (disease management, case management, nurse helpline, drug management, and performance provider network)

seem to be meeting their implementation targets. Particularly for the disease management program, I would like more nuanced information on specific targets for high-quality care and whether these targets are being met.

Cost Outcomes

2005 was a baseline year. I would not expect to see a change in the trend of health-care and pharmaceutical costs, and no significant change was seen.

2: Implementation

To what extent do the results from 2005 suggest that the first year of implementation has put the county on track to realize its goals of improving employee health, bringing about organizational change, and slowing cost increases?

The 2005 results from the major program areas are encouraging. In the area of Employee Wellness, HRA participation is high, and there have been extensive efforts to foster healthy behaviors by optimizing health insurance benefits and introducing workplace policies and programs. The four health behaviors targeted are important: flu vaccination, healthy eating, physical activity, and tobacco cessation. In the area of Utilization Management, the HRI has implemented five well-accepted programs, and employee participation is on-target.

To guide and evaluate these two program areas in future years, however, we clearly need more information. As I implied in my answer to Question 1, we need specific information in three areas: 1) program implementation, 2) employee participation, and 3) employee health behaviors. In the area of Employee Wellness, I would suggest that we add disease screening to the four health behaviors above. The choice of diseases to target should depend on baseline data from the HRA but should be drawn first from the high-impact, high-value list released recently by the Partnership for Prevention (www.prevent.org/images/stories/clinicalprevention/employersguide.pdf). The list includes: alcohol misuse, blood pressure, cholesterol, and cancers of the breast, cervix, and colon.

Where will the information come from? Information on program implementation will need to come from the programs themselves, for example, the number of worksites covered by flu vaccination. Information on employee participation can come from the programs, for example, counts of employees participating in physical activity programs, or from the upcoming employee surveys. Information on employees' health behaviors can come anonymously from the HRA. In some cases, obtaining program-participation information may require alterations in contracts with vendors or health plans. For example, information on the use of a telephone quitline for tobacco cessation may have to be aggregated from multiple sources.

In the area of Utilization Management, much of the focus to date has been on employee participation as well as on Cost Outcomes. Collecting information on clinical performance measures at a finer level would be consistent with the approach of the Puget Sound Health Alliance. Important clinical areas to measure include control of blood pressure, cholesterol, and diabetes.

Have communication strategies, e.g., messaging, supported implementation effectively?

The communication strategies to date have been impressive. There has been a thoughtful effort, led by senior management, to reach middle managers, as well as workers, with information about the importance of the HRI and the way in which it works. A variety of means of communication have been used. These have included heavy face-to-face communication, through leadership meetings and information sessions held throughout the county. The participation in the HRA suggests that this communication has been effective. The upcoming employee surveys provide a good opportunity to assess employees' exposure to, and absorption of, key messages.

3: Adjustments

Given the data available from the first year of implementation, what adjustments would you recommend?

I have laid out many of my suggestions for improvement above. To recap, in the coming year, I believe there should be much more measurement of program processes (program implementation and employee participation) and intermediate outcomes (employee health behaviors).

In the area of communication, I would like to see more emphasis on flu vaccination and tobacco cessation. In Washington State, flu vaccination levels are only about 30% among employed, insured people aged 50-64 years (Behavioral Risk Factor Survey, 2004-5), so this is an important area for improvement. Telephone quitline use by smokers is only about 1% to 2% per year without promotion but doubles or triples with promotion. Communication should be guided where possible by information from the employee surveys on perceived barriers to flu vaccination and use of the telephone quitline. This sort of information will also be useful for planning program efforts aimed at disease screening, healthy eating, and physical activity.

4: Sustainability

Thinking about the future, what will be necessary to ensure that changes are sustainable? Are there any developing trends that could positively or negatively impact the HRI over the next three to five years?

For a workplace program on healthy eating and physical activity to be effective, social norms within the workplace must change. Achieving these changes will require persistent efforts to increase awareness and change attitudes as well as group programs, including competitions, that are long-lasting (a year or two or three) and foster social support. These programs will need to be refreshed over time, but they should not flit about in their basic messages. The basics of healthy eating, physical activity, and clinical prevention are pretty simple and change only slowly, no matter what the Internet says that day. Avoid being distracted by potentially expensive health fads that lack evidence and are distracting.

Pete Penna, PharmD

President, Formulary Resources, LLC

Area of Expertise: Pharmacy Plan Design and Strategy

1: Program Design

What does the first year of implementation tell us about the soundness of the design and assumptions underlying the HRI?

There is little data or information (in the pharmacy realm) to determine an answer. Perhaps the most significant issue is that there appears to be little attention devoted to defining a plan to manage pharmacy costs, utilization and outcomes. Initial baseline data supplied in the report is a preliminary step, but much more in-depth information will be needed to craft a suitable plan. Part of that plan should deal with ongoing information needs and reports.

2: Implementation

To what extent do the results from 2005 suggest that the first year of implementation has put the county on track to realize its goals of improving employee health, bringing about organizational change, and slowing cost increases?

There is no data to suggest that pharmacy costs/utilization/outcomes are moving in the right or wrong direction. Projections based on 5 months of information (January through May) that are annualized do not lend credibility. With electronic claims processing of prescription data being the norm in this country, detailed pharmacy claims data should be much more readily available, and much more timely.

Have communication strategies, e.g., messaging, supported implementation effectively?

I could find no information in this regard, other than the employee brochure. There needs to be messaging to patients, prescribers, and pharmacies that detail the plan, how it will affect them, etc.

3: Adjustments

Given the data available from the first year of implementation, what adjustments would you recommend?

There was no information related to quality improvement and pharmacy. Examples of areas for development might include:

- Adherence to established treatment protocols
- Percent of patients achieving and maintaining therapeutic goals (e.g. blood pressure, lipid levels, HbA1C, etc.)
- Percent of patients adherent to their medication regimens over time
- Identification of patients at risk from their drug therapy
- Resolution of drug interactions
- Reporting of adverse events

4: Sustainability

Thinking about the future, what will be necessary to ensure that changes are sustainable? Are there any developing trends that could positively or negatively impact the HRI over the next three to five years?

• First, a standard set of reports needs to be designed and generated so that plan executives and staff can see what is happening with the pharmacy benefit (monthly,

- quarterly, annually), and which can be queried to identify over/underprescribers, trend changes, patients at risk, etc. (This capability may already exist)
- Second, the pharmacy benefit design needs to be updated, for example by increasing the
 copay differential for brand drugs when a generic is available (or outright prohibiting
 substitution unless a specific exemption is granted). Consideration could be given to
 incenting patient behavior by tactics such as refunding a portion of copays once a patient
 has demonstrated long term adherence with medication regimens.
- Third, either a P and T committee needs to be empowered (or if one exists, it may need an evaluation/updating) to looks after the pharmacologic needs of the employees and their families on behalf of King County. This committee should be given oversight of a pharmacy quality improvement plan. This committee should also be responsible for overseeing a response to the forthcoming IOM reports on medication safety.
- Fourth, the formulary should be evaluated to determine potential savings opportunities related to drug choice and/or drug toxicity.

Neal Sofian, MSPH

CEO, The NewSof Group

Area of Expertise: Wellness Outreach and Education

1: Program Design

What does the first year of implementation tell us about the soundness of the design and assumptions underlying the HRI?

The implementation is very well thought out. It makes sense for there to be all three levels of effort to change the culture of both the greater Metro area as well as the culture of the county facilities. There will likely need to be a growing level of publicity around the regional work as the results of the County program begin to appear.

The fact that there isn't any indication of behavior change yet is to be expected. These changes won't significantly manifest themselves until year 2 or 3.

I think tying the disease management program to a guarantee makes sense. The data on disease management is not totally convincing. That same sort of guarantee could be valuable for other behavioral areas. For example there is no reason that cessation cannot be tied to an outcome guarantee. Many of the DM companies are moving toward behavioral interventions based on their own data as well as the growth of interest in health management. It isn't clear yet that they have much expertise in actually changing behavior however.

2: Implementation

To what extent do the results from 2005 suggest that the first year of implementation has put the county on track to realize its goals of improving employee health, bringing about organizational change, and slowing cost increases? Have communication strategies, e.g., messaging, supported implementation effectively?

The high level of participation in the HRA during 2005 is very encouraging toward the hope of meeting the long term goals of this work. However, we need to assume that some unknown percentage of the people completing HRAs did so simply because of the incentive system and are not highly committed to making significant lifestyle change. We must also assume that there is some degree of misinformation (some intentional, some wishful thinking) within the HRA data. That is OK and to be expected. Nonetheless we might want to consider externally verifiable means to determine the accuracy of the data. For example some companies have moved to using bio metric data to verify smoking status, etc (Health IQ).

3: Adjustments

Given the data available from the first year of implementation, what adjustments would you recommend?

As the county moves into its next year of service it should explore the most effective means to integrate medical care with the health promotion and care management services that are currently being implemented. One approach would be to offer onsite medical care in the larger County facilities. This could address the cost of the direct care as well as provide a potential staff that could coordinate the transition of folks into health management and disease management services. Given that there is a guarantee tied to the DM program moving the maximum appropriate employees into the program would be good. Beyond the referral value, this service could provide a focus on preventive care and coordination to medical services that meet best practice standards. Onsite staff can serve as a starting point for dealing with workers compensation issues as well.

There will need to be a more refined means to determine what level of intervention would be most appropriate for each individual. The current risk-based rating of folks is pretty much the state of the art, but the bar is set rather low for this across the board in the industry. The work of folks like Dee Edington, focusing on the combinations of risk factors to create 'dangerous conditions' could help move intervention triage to a much more refined level.

Once we have a better means of assessing people with regard to level and type of risk, an algorithm could be development to move participants into the most appropriate level and modality of intervention. No one modality is most effective. There is a heavy focus on telephonic interventions, which can be effective but don't scale as well as some other forms of intervention. We should look at multiple modalities of intervention. Right now most online services are more informational than interventional. There are beginning to be new options that could be considered like

- Self Help Works
- Hummingbird Coaching
- MEDeCOACH

There may be opportunities to combine a number of alternative programs into a more integrated suite of interventions with a common dash board to tracking participation in all of all of them.

4: Sustainability

Thinking about the future, what will be necessary to ensure that changes are sustainable? Are there any developing trends that could positively or negatively impact the HRI over the next three to five years?

To determine the true effectiveness of all county interventions, we will need to continue to find more effective means to track time loss. Given the limitations of the reporting system it could be worthwhile to consider a small study of time loss with a representative cross section of work groups that could serve as a surrogate estimate for time loss and the effectiveness of both health management/behavioral interventions and onsite medical if that were initiated..

It would also be worth considering developing onsite pharmacy facilities. Organizations like Caesars entertainment have implemented this strategy in larger facilities. Their major focus is to move as many people as possible to appropriate generics. The results have shown a significant move toward generics plus a higher level of compliance in general. As part of this it would be valuable to consider the value-based pharmacy benefit structure currently developed at Pitney Bowes.

With regard to building a significant level of community (regional) support, it would make sense to have a more effective means for companies and healthcare institutions to be able to share their best practices. A web environment that would allow different organizations to be able to contribute and share resources, strategies and tactics would be effective.

Cindy Watts, PhD

Professor, University of Washington Health Services

Area of Expertise: Measurement and Evaluation

(Reviewer's note: Former Oregon Governor John Kitzhaber made a presentation to the (Washington) Governor's Blue Ribbon Commission on Health Care on September 21, 2006. He made an impassioned plea for more rationality in the nation's health care system, particularly with regard to creating incentives within the system to encourage the behaviors from all market participants (including government) that will:

"Maximize the health of the population by creating a sustainable system that uses public resources in health care to provide a defined set of effective health care services to everyone."

With the exception of the last piece of the vision ("...to provide ... services to everyone"), the HRI as described in the review materials is consistent with Gov. Kitzhaber's vision [the "provide services to everyone" task might fall into the County's purview in another of its roles, but not in its role as employer].)

1: Program Design

What does the first year of implementation tell us about the soundness of the design and assumptions underlying the HRI?

The first year of implementation appears to have set the stage for the package of reforms contained in the HRI. Certainly the logic behind the connections (good behaviors foster healthier employees who use less health care and so cost less to cover; good information that is easily available to all parties, coupled with accountability, leads to better choices of provider and better treatment strategies, which in turn lead to lower health care expenditures at least over time; all of these changes are more likely and more sustainable in organizations that are both committed to and structured to support the overall vision) is excellent and well

supported by the literature on incentives and organizational change. There is nothing in the first year outcomes to suggest that any of the pieces of HRI have been poorly planned.

A strength of the design, but one that makes it harder to evaluate, is the strategy of combining a variety of programs that work together to achieve the County's goals. Because of the interaction of the pieces, none can be evaluated completely separately. The parallel (and not coincidental) activities of the Puget Sound Health Alliance may also contribute to the effectiveness of the County's HRI if they succeed in affecting the practice patterns and expectations in King County health care markets. Another contextual factor that works to the advantage of HRI is the relative stability of the County's workforce. The behaviors that are targeted by the HRI are likely to take some time to change and take even longer to show up in measurable differences in either health status or health care expenditures. The stability of the workforce increases the likelihood that employees stay with the County long enough for improved outcomes to be observed.

If effective, the HRI may have an impact beyond its own employees. To the extent the program induces individuals to be more discerning consumers of health care services, physicians may find that they need to change either their attitudes or their practices (or both) in response. Some of these changes, particularly if they are accompanied by similar changes in the behavior of other individuals (such as those employed by other Alliance members), may affect the way these physicians treat all their patients.

2: Implementation

To what extent do the results from 2005 suggest that the first year of implementation has put the county on track to realize its goals of improving employee health, bringing about organizational change, and slowing cost increases?

The results of 2005 suggest that the county appears to be on track with its goals. Participation in each of the elements/programs has been either on par or ahead of expectations. The fact that there are no measurable effects on expenditures as yet is not unexpected (and may be altered as more complete data for the year become available). Many of the behavior changes that should ultimately result from full implementation of HRI will take some time. Further, one large piece (the differential premium/copay for different levels of participation) has not yet been implemented. All of the county's goals are likely to take

some time. Unhealthy behaviors, uninformed choices by consumers, and "otherly incented" choices by providers that result in higher provider payments took time to develop. They will take time to change to any measurable degree.

A strength of the implementation strategy is the tailoring of some of the programs to relevant subpopulations within the County's workforce. The example in the video of the Metro employees using County facilities to have work out classes is illustrative. Additional mechanisms might be found to build on this idea (e.g., connecting employees such as pregnant women who share similar health care/health education needs or others who face similar barriers to achieving wellness goals).

Have communication strategies, e.g., messaging, supported implementation effectively?

The real test of the effectiveness of communication is, of course, participation and behavior change. The levels of participation indicate that communication strategies have at least been somewhat supportive. While my read of the communication materials is very positive, I am neither a county employee nor a county supervisor. Continuing to evaluate the adequacy of communication is important, however, as effective communication is central to HRI meeting its goals. This will probably be particularly true of the next phase in which employees will pay much higher premium shares and copays if they don't actively participate in the Healthy Incentives program. Uninformed employees who suddenly see a large increase in their health insurance contribution are likely to be very vocally displeased. The recent experience of Regence in attempting to make significant changes to the benefit structure underscores this point. The same point should be made about provider reactions as the program to alert caregivers about problems with their treatment decisions expands (especially if many consumers are notified directly of their providers' failure to act).

The newly announced suit that was filed against Regence may have some spillover effect on the HRI, although it is difficult to predict what that impact might be at this point. It certainly reinforces the importance of keeping stakeholders actively, continuously, and directly (as opposed to through their agents) involved in program changes that affect them.

The existence of a grace period and a transparent appeals process is a good mechanism to deal with transition difficulties. The County appears to have done an adequate job of building these into the HRI, although only experience will determine their effectiveness.

3: Adjustments

Given the data available from the first year of implementation, what adjustments would you recommend?

I think the most important recommendation is to stay the course. Because of the long term nature of the county's goals, it would be very easy to get impatient before the HRI has a chance to play out. While ongoing evaluation is important, it is equally important not to over-evaluate -- that is, to require measurable outcome (as opposed to process) changes too quickly.

In keeping with the point above, I would recommend careful tracking of the adequacy of communication as the next phases of the HRI are implemented to avoid strong negative reactions that sidetrack the program.

I think it is essential to appropriately manage the expectations of the stakeholders, particularly the County Council. Offering (or allowing) expectations of quick or easily quantifiable outcomes could easily undermine the HRI approach, which is by its nature effective only in the long run.

In terms of evaluation, I think that a wider variety of evaluative tools might be used. Employee surveys to measure changes in interim outcomes and satisfaction would be useful. Focusing on the impact of HRI on specific subpopulations could also be useful to better target future changes in program design. It is important to provide a variety of outcome and process measures, and resist any effort to simplify the assessment of the HRI based on a simple cost benefit ratio or return on investment figure.

4: Sustainability

Thinking about the future, what will be necessary to ensure that changes are sustainable? Are there any developing trends that could positively or negatively impact the HRI over the next three to five years?

The document titled "King County Health Promotion Leadership Committee" outlines some very important cautions for the future:

- Funding for the initiative,
- Command and control organizational structure,
- Priorities of leadership,
- Risk adversity,
- Labor environment,
- Communication challenges,
- Distrust of management, and
- Entitlement mentality.

Any one of these factors could derail the HRI at any time. The real key to sustainability is continued:

- Good leadership,
- Good communication with all affected parties,
- Clarity of mission,
- Attention to complacency, and
- Reasonable outcomes.

A particular vulnerability of the HRI is that it is being implemented in a setting where its original and primary champion is an elected official. If Executive Sims should leave office,

or be forced by the political environment to change focus, the HRI may not be sustainable. This is a particular risk in the early phases of the program before it has a chance to show measurable results. The longer the program is in existence and the more deeply it is integrated within and across the County's infrastructure the more protected it will be from shifting politics and changing leadership.

In terms of external trends, there are several that will probably work to reinforce the HRI. The Leadership document noted the passage of 901 as a potential negative (because of push back from smokers and others worried about too much government intervention). An alternative possibility is that 901 will encourage more people to quit smoking, and to make people become accustomed to and expect smoke-free restaurants and other public places (Clearly changes in the political winds around government intervention will have an everchanging impact over time). King County is not the only employer or government entity concerned about rising expenditures and unhealthy employees/residents. The behavioral change initiatives of the county, while innovative now, may become more the rule than the exception in a few years. Research to help define effective and less effective strategies is increasing. This will allow the county to refine its strategy over time (as will the evaluation of its own experience).

In terms of negative external trends, one possibility is that private sector employers will pull away from providing health insurance at all. Should this happen (to a greater degree than it is already happening), the Puget Sound Health Alliance may have a harder time engaging employers in its partnership, which will have implications for the outer circle of the county's three circle strategy. It might also mean that the interest in HRI as a cost saving device will wane if it becomes easier to simply cut benefits.